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SOME REMARKS ON THE POSITION OF CERTAIN REMITTENT FEVERS HITHERTO FREQUENTLY CLASSED AS MALARIAL, WITH ILLUSTRATIVE CASES AND TEMPERATURE CHARTS

J.H.Tull-Walsh

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inhabitants of affected villages, when they make the change, must take their sick along with them. Though the mortality from *kalá-ázár* is at a minimum during the cold-weather months, the death-rate even then is very little below the average of the year. In 1896, 23·21 per cent. of the *kalá-ázár* deaths occurred during the months of December, January and February.

(*b*) He recommends that means should be taken to prevent the entry into tracts, not affected with the disease, of persons suffering from the *kalá-ázár*, and with a view to giving effect to this proposal, he suggests that the provision of the lately-passed Epidemic Diseases Act, which renders this action possible, should be put in force. It is certainly the case that *kalá-ázár* has usually been checked when it reaches a broad belt of uninhabited country, and there have been many examples of outbreaks of the disease in villages soon after the arrival in them of persons suffering from *kalá-ázár*, but as, in order to be effectual, the provision would have to be in force for a considerable time, and as even medical men can with difficulty recognise single cases of the disease, I am very doubtful whether the provision of the Epidemic Diseases Act referred to should be put in force for this purpose. The inhabitants of non-affected villages might, however, be encouraged to prevent people, believed to be suffering from the disease, visiting their villages.

(*c*) Appendix II attached to this report is a note on the spread of *kalá-ázár* and how it may be checked. Dr. Rogers recommends that this note should be translated into the languages of the inhabitants of the Upper Assam Valley, and distributed gratis to the heads of villages in both the affected and threatened tracts of country. I strongly recommend that this suggestion be given effect to.

Dr. Stephen then expresses his concurrence with the prophylactic measures suggested by Dr. Rogers to prevent outbreaks among coolies working on tea plantations, and concludes by alluding to the energy and zeal which Dr. Rogers had evidenced in the course of his observations. He adds that he considers Dr. Rogers has proved that: (1) the disease is distinct from anchylostomiasis, thus confirming the long-held and almost universal opinion of other medical officers in Assam; and that he has (2) shown the close alliance between malarial fevers and *kalá-ázár*; but that he has failed to prove its identity with malarial fever, and that the disease was carried by human intercourse from Rangpur to Assam, or that it arose from an intensification of the ordinary malarial fever of that district.

SOME REMARKS ON THE POSITION OF CERTAIN REMITTENT FEVERS HITHERTO FREQUENTLY CLASSED AS MALARIAL, WITH ILLUSTRATIVE CASES AND TEMPERATURE CHARTS.

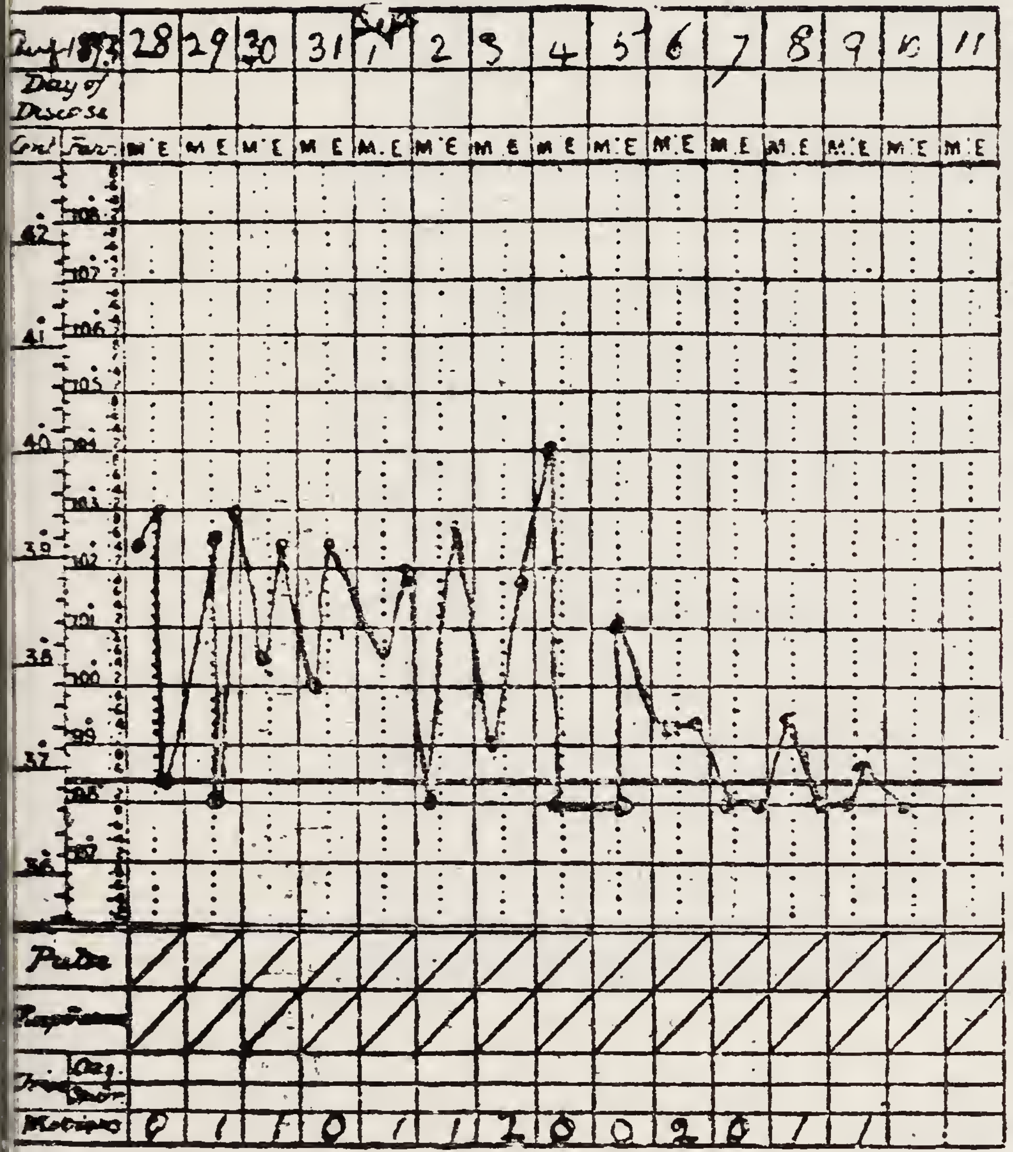
By Surgn.-Maj. J. H. Tull-Walsh, I.M.S.

All authors admit that the *remittent fevers* vary very much in type, and years ago Norman Chevers wrote concerning them as follows:—"*Remittent fever* is not in my opinion modified or aggravated *intermittent* fever." So far as many of the cases are concerned I quite agree with this opinion, as do a great number of medical men in this country. *Remittent fevers* classed under *malaria* seem to fall into two main groups.

(*a*) Ordinary *remittent fevers* presenting in the blood 'crescents' or other forms of the *plasmodium malariæ*. The attacks are not very severe, lasting generally a week, or at most 15 to 35 days. Cases I and II and charts taken from my note-book are given as examples for comparison.

(*b*) Severe or 'pernicious' *remittent fever*.—A serious form of fever with many symptoms resembling those of *typhoid fever*, and lasting from 30 to 70 days or more—Case III and chart. There are strong reasons for thinking that many of the 'fevers' classed by custom under this 'heading' should be removed entirely from the catalogue of *malarial* diseases.

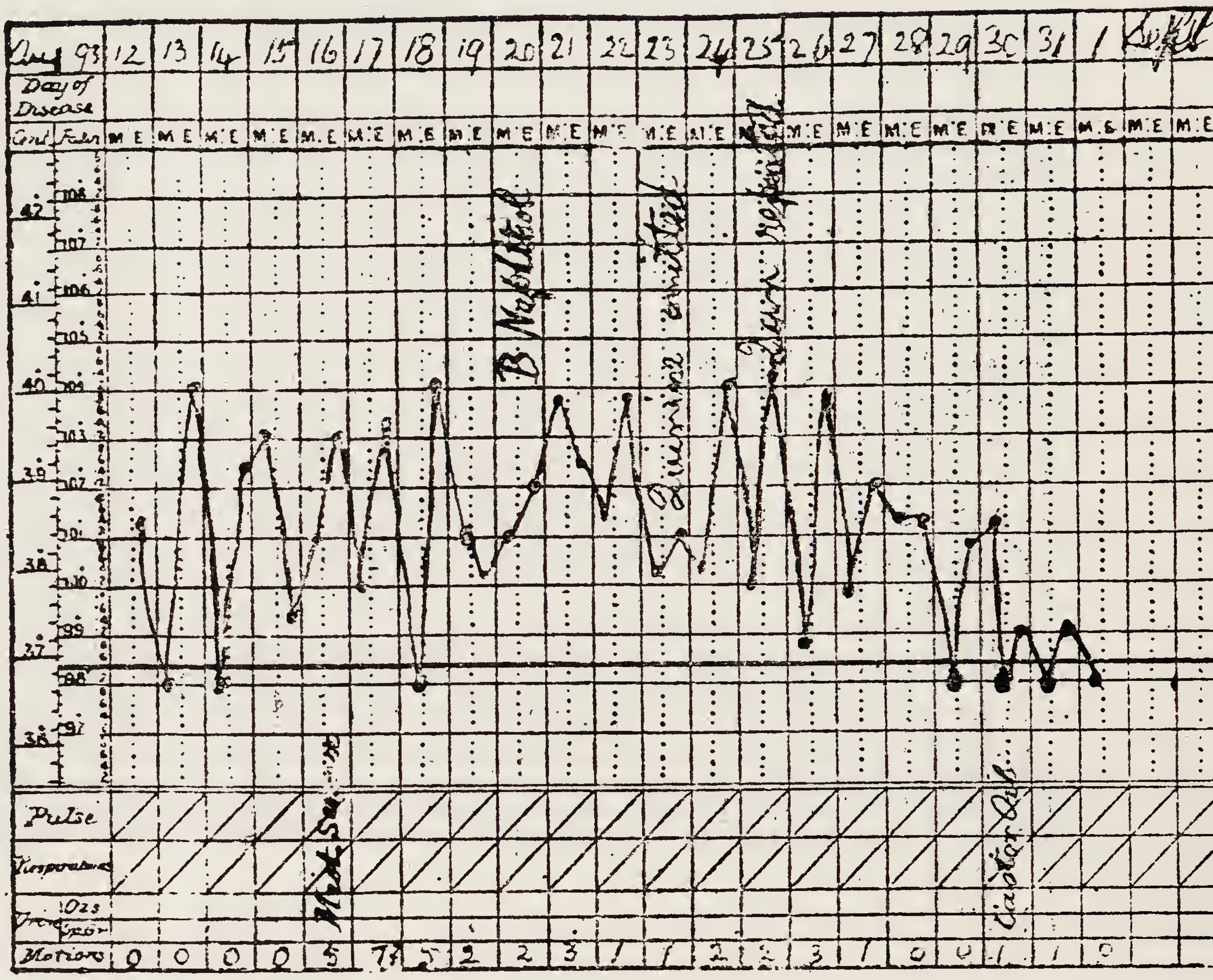
There is further a diagnostic test in the way many *remittents* react to quinine, and Osler believes that where we find no benefit from quinine we are not dealing with *malaria*. Many of these cases present no signs of the *plasmodium malariæ* in the blood. They do, however, present certain features which would lead one to regard them as in some way clinically allied to the *typhoid fever* class. Up to within the last few years all *remittents* occurring in malarial areas (not markedly *typhoid* or owning other accepted origin) have been included under the 'heading' *Malaria*. It is, I admit, often very hard to distinguish many of these anomalous cases from ordinary *malarial remittents*, and perhaps this difficulty has given rise to the term "*typho-malaria*" as used by some writers. It only requires a little thought to convince us that, having accepted the *plasmodium malariæ* as the active cause of true *malaria*, we cannot possibly have a disease, which, from an etiological standpoint, is a 'cross' between *typhoid fever* and *malarial remittent fever*. The two diseases might, of course, exist together, and many prolonged *remittents* present, as we have seen, certain symptoms, hæmorrhage, etc., which occur also in *typhoid fever*. Further, men of any experience know that we meet with very curious and *atypical* cases of *typhoid fever* (Case IV and chart). A somewhat similar case



CASE I.

Remittent Fever—Malarial ordinary.

I. R., Eurasian, aged 12. Ill three days previous to admission; admitted into the P. G. H., Calcutta. on the 26th August, 1893.



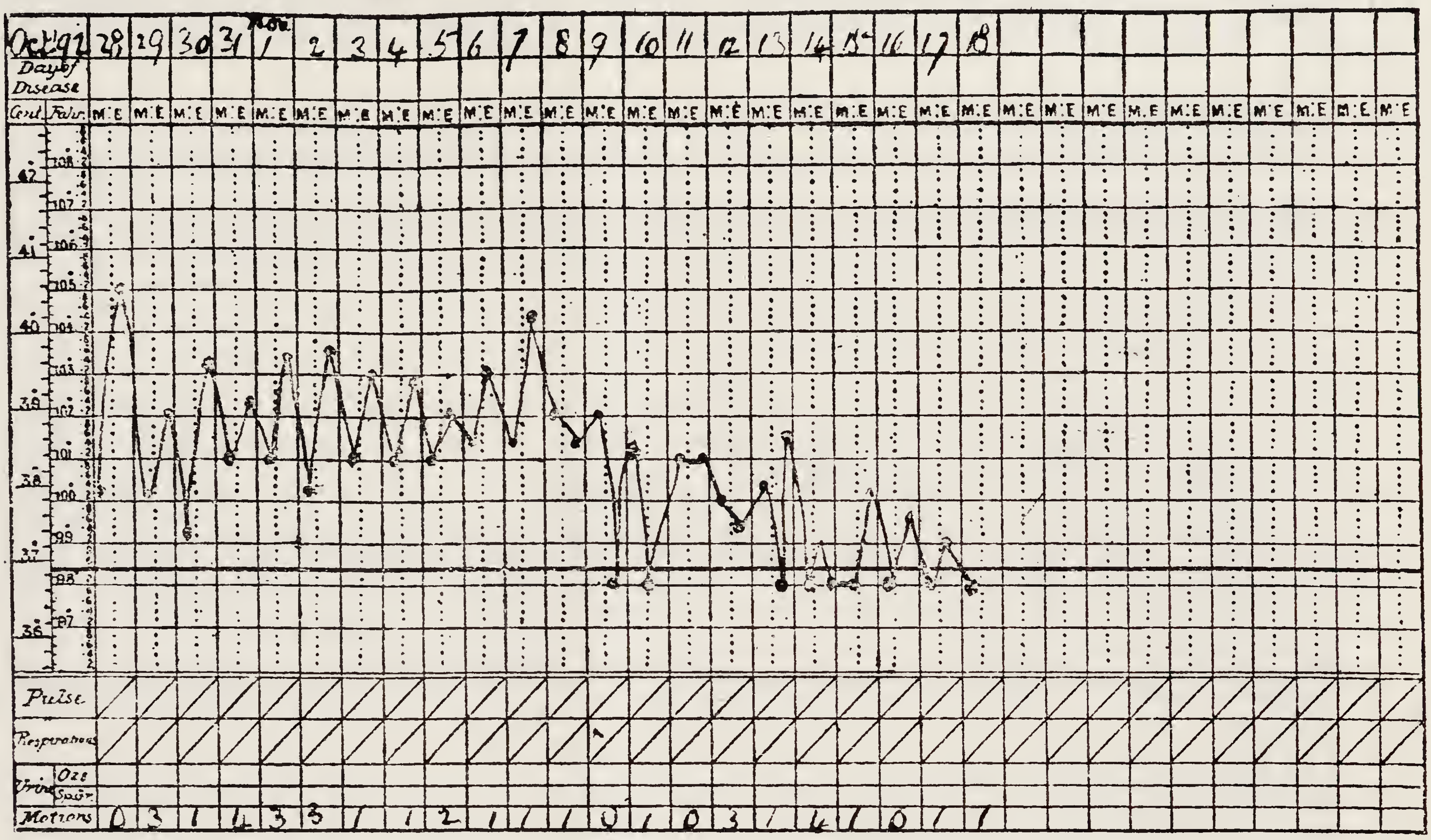
CASE II.

W. W., European sailor, aged 26.

has been reported by Dr. Carslow (*Lancet*, ii, 1890). Dr. Martin, of Louisiana, speaks of certain curious long-continued fevers not resembling those mentioned in text-books of medicine; slow, remittent fevers resisting quinine. He points out that the word '*malaria*' often covers a want of proper diagnosis, and alludes to the dangers which would arise if *typhoid fever* were mistaken for a *malarial remittent.* Dr. Martin thinks it possible that many of the cases of so-called "*typho-malarial fever*" are modified forms of *typhoid,* and it must ever be borne in mind that *typical typhoid fever* is much more common in temperate climates than in hot countries. Some of these Louisiana fevers differ, however, from *typhoid* and also from true *malaria.* The temperature ranges between 99°F. and 103°F., the fever lasts three to nine weeks, and the patients are not greatly exhausted by the disease. Osler and others also admit a difficulty with regard to certain *remittent fevers.* Case No. IV shows that *typhoid fever* may closely resemble these fevers, epecially the kind known as *Malta fever* (cf. Case V and chart). These anomalous *remittents* should be classed apart from true *malarial fevers,* and a noteworthy effort in this direction has been made in the case of *Malta fever* and in the case of certain remittent fevers occurring in Massowa. Surgeon-Captain Hughes, M.S., studied *Malta fever* for two and-a-half years, working in the military laboratory, and observing cases in the military hospital, Malta. He describes a *remittent fever* of a peculiar kind resembling somewhat, in a general way, the severe *malarial remittents,* and also, to some extent, *typhoid.* It differs from *typhoid fever* in range of temperature, duration, tendency in a few cases to periodicity, absence of lesions in Peyer's patches, less sordes and dryness of the tongue, less stupor and delirium. The *typhoid* bacillus is not found in the 'stools,' which are frequently constipated.

Malta fever differs from ordinary *malarial remitients* in the absence of *plasmodia* from the blood, in the resistance which it offers to treatment with quinine, and in the presence of certain micro-organisms in the blood and tissues. This organism is a *micrococcus,* and has been found in eight cases by Bruce, twice by Gibbs, and eleven times by Hughes. The organism is known as the *micrococcus militensis,* and Bruce was able, by inoculating with a pure culture, to produce in monkeys a similar disease. Hughes repeated these experiments with like results.

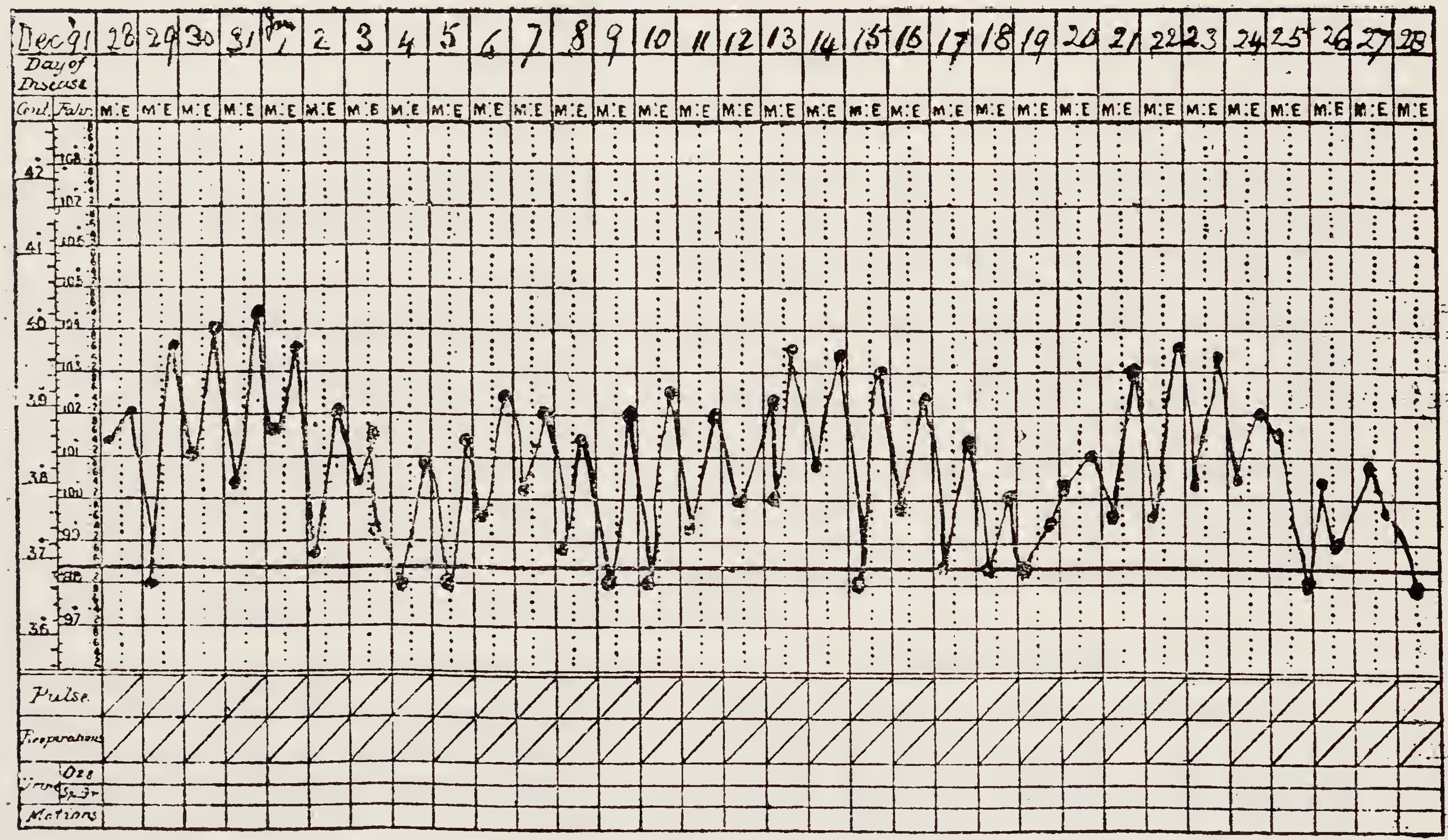
Malta fever may last for six months, or even more, and is not unfrequently followed by rheumatic pains in the joints and limbs; these are not improbably of a septic nature. Death may occur from hyperpyrexia, exhaustion, or from lung complications. The mortality among cases



CASE III.

Remittent Fever, Malarial, severe type, 68 days in hospital.

E. A., Eurasian, aged 25.



CASE IV.

Anomalous Case of Typhoid Fever for comparison with severe cases of Remittent Fever (Malarial) and Cases of Malta Fever.

. N., Irish, aged 24.

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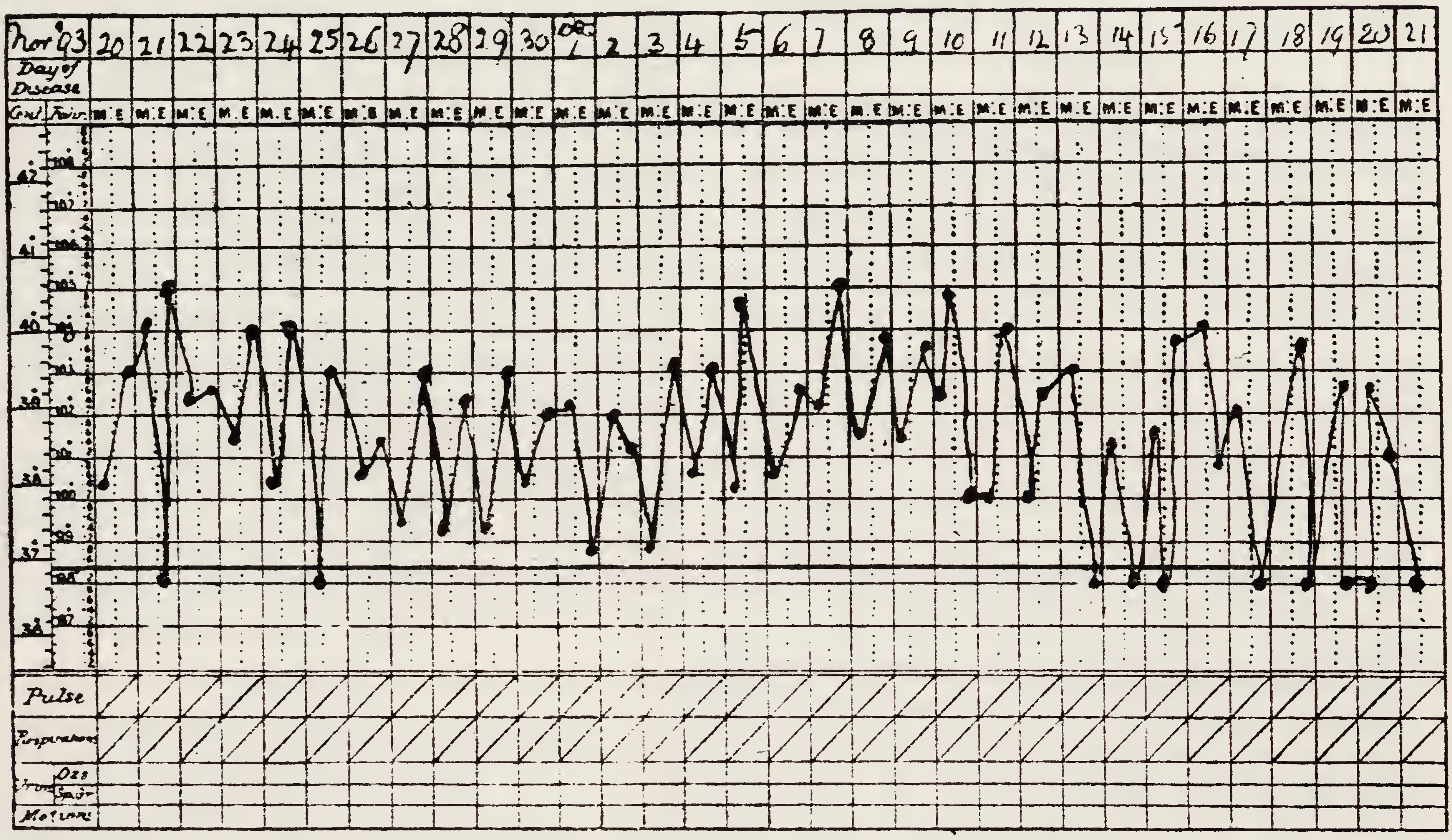
treated in hospital is not, however, very high—2 per cent. according to Hughes.



CASE V.

Malta Fever.

H. R., aged 25, seaman, H. M. S. *Boadicea*.

The writer has had an opportunity of studying the clinical features of this disease in Calcutta in the persons of sailors admitted to hospital from H. M. S. *Boadicea* (Case V and chart).

These men had been taken ill soon after leaving Malta, and while their temperature charts resemble, in the main, those given by Hughes, they also in some respects resemble those of cases of severe *malarial remittent fever* which we are accustomed to see in India. I regret that the blood, though examined for the *plasmodia* of *malaria*, was not stained and examined for *micrococci;* indeed, at the time (1891) I was not aware of the existence of the *micrococcus militensis.*

Pasquale, speaking of certain fevers occurring in Massowa, and similar, in many respects, to *malarial fevers,* says that no *amœba* could be found in the blood, nor was any satisfactory result obtained from treatment with quinine. Pasquale is certain that these were not cases of *typhoid fever.* The critical period only lasted about ten days, though the convalescence was sometimes prolonged. He found a *micrococcus,* probably similar to that found in *Malta fever.*

One great feature which strongly divides the true *malarial fevers* from those of bacterial origin is that, while these latter are to a great extent auto-protective, the victim of an attack of *malarial fever,* either *intermittent* or *remittent,* is rendered only the more liable to subsequent attacks, which may occur even after he has left the malarious region. Many an European who has quitted India or Africa for his home in England has, when in low health, been reminded of his former troubles by a sharp attack of *ague.* The question is one of great interest to us in India, and I would suggest that those gentlemen who work at peace in the laboratories of India might assist us by making complete bacteriological examinations in doubtful cases.

CASES I AND II.

(*Remittent Fever—Malaria, ordinary.*)

I. I. R., Eurasian, aged 12. Ill three days previous to admission; admitted into the Presidency General Hospital, Calcutta, on the 28th August 1893. The only noticeable point about this case is the obstinate constipation. *Plasmodia* were seen in the blood, but no "crescents" or other forms. Discharged cured on the 11th

September. The fever yielded readily to purgatives with quinine and phenacetin. Normal temperatures in this and other cases of *remittent fever* are the result frequently of the administration of antipyretics. Typical charts then can seldom be obtained from persons under treatment.

II. W. W., European sailor, aged 26. Ill about three days previous to admission to hospital, and ascribed his illness to a "chill" which he felt while sleeping on deck while the ship was lying moored in the Hughli river. Admitted into the Presidency General Hospital, Calcutta, on the 12th August 1893. *Treatment*—Quinine and antipyrin with beta-naphthol while the bowels were loose. The disease began with marked constipation, and the diarrhœa was partly provoked by the purgative given (see chart). It will be noticed in this case and in Case IV that the remissions are less marked during intestinal disturbance such as diarrhœa. *Plasmodia* seen in the blood. Discharged recovered on the 2nd September. It might be better to keep some of these cases longer in hospital, but the patients will not stay, as a rule, when they feel free from fever and practically well.

CASE III.

(*Remittent Fever—Malaria, severe type.*)

Sixty-eight days in hospital.

E. A., Eurasian, aged 25, employed in the Telegraph Department. Admitted into the Presidency General Hospital, Calcutta, on the 28th October 1892 According to the patient's statement he had been ill for 23 days previous to admission. The usual febrile symptoms were present, and the patient complained of insomnia; no spots on the abdomen; tongue 'furred,' not dry; no enlargement of spleen. The bowels were not open on the day of admission, but after an enema, acted freely and continued loose for some days (see chart). On the 31st October and 1st November the stools contained some blood; this ceased on the 3rd November and did not recur. The stools were afterwards sometimes loose, sometimes constipated, always of a bright yellow colour. The case was treated with quinine, phenacetin and diaphoretics. Sulphonal and morphia were given for the insomnia, but were not required after the 5th November. On the 8th November, beta-naphthol, grs. v, was given every four hours, and relieved some enteritis which was present. The temperature became normal on the 17th November, and remained normal until the 5th December. The patient was somewhat constipated and complained of headache. The fever returned but gave way to treatment, as above, with confinement to bed. From the 30th November to the 5th December the patient was not taking any medicine. Discharged January 3rd, 1893. In the blood of this patient there were occasionally a few *plasmodia*, and once or twice "crescents" were seen; generally nothing particular could be observed. Though a severe case there was never any delirium or dullness of the mental faculties, nor was the patient so *ill* as those who suffer from bacterial fevers such as typhus, typhoid, and some other anomalous remittents, of which I shall give examples.

CASE IV.

[Anomalous case of *Typhoid Fever* for comparison with severe cases of *Remittent Fever* (*Malaria*) and cases of *Malta Fever, etc.*]

F. N., Irish, aged 24, travelling actor. Admitted into the Presidency General Hospital, Calcutta, 20th November 1893; died 16th February 1894.

On admission the patient stated that he had suffered from 'fever' (probably malarial) off and on during the previous three months; bowels open regularly, and the fever accompanied with shivering each afternoon. The illness for which he was admitted had, according to his statement, lasted six days. The spleen and liver were both slightly enlarged, the spleen became smaller; no albumen in his urine on admission. He never suffered from diarrhœa; indeed, his bowels were seldom moved without an *enema* or an aperient. On the 23rd November there was a trace of albumen in the urine. Tongue at first covered with white 'fur' and red at the tip; after the first week less 'furred' and drier. No spots seen on the abdomen; slight delirium at night and insomnia; some blood in the stools on the 27th day, but on no other occasion. After several short relapses accompanied by obstinate constipation, relieved by castor oil emulsion in small and regular doses, the patient seemed to be on the way to recovery and was able to sit up by the bed-side. One day after seeing the patient in the next bed die he became faint, with shallow breathing and a weak pulse, and died apparently of shock and syncope.

Quinine had little or no effect on the progress of the disease, and though given regularly at first, it was omitted without any difference being perceptible. I regarded this case as one of "pernicious" *remittent fever*, as did two other medical men who saw the temperature chart, and noted the condition of the patient on one or two occasions. At the same time I failed to find any of the forms of the *plasmodium malariæ*. The temperature always rose when the bowels were confined, or on any sudden increase in diet.

This latter point was suspicious; but, on the other hand, many cases of *malarial fever* are accompanied by severe enteritis. The age of the man was no guide in this case, as all ages suffer from *remittent fever*. The diagnosis was not borne out by the *post-mortem* examination:—

Heart—Both ventricles filled with clot; muscular tissue soft and friable; valves normal.

Lungs—Somewhat congested; no pneumonia and no tubercle.

Liver—Marked fatty degeneration.

Spleen—Apparently normal; weighed 6 ounces.

No blood or fluid in the peritoneal cavity.

On opening the small intestines, the ileum was found to contain a few small and old blood clots, and also several round, sharp-edged ulcers were seen on Peyer's patches, with floors so thin as to be torn in the washing in one or two cases. There were also numerous small ulcers at the entrance to the cæcum. There were no parasites present, and the large intestines, though slightly congested, were free from ulceration. Brain, kidneys, etc., normal.

I am of opinion that this was a case of typhoid fever, whether combined with any malarial element it is difficult to say. The case does, however, in many respects resemble reported cases of 'pernicious' *remittent fever* due to *malaria*, and also resembles cases of *Malta fever.*

CASE V.

(*Malta Fever.*)

H. R., aged 25, seaman, H. M. S. *Boadicea.* Unwell sometime previous to admission, and seriously ill for five days. Admitted into the Presidency General Hospital on the 28th December 1891. Usual febrile symptoms with high temperature and anxious expression; stools loose on admission; varied afterwards; nothing typical about them, and no blood at any time. There was never any albumen in the urine. Spleen not enlarged. No malarial *plasmodia* seen in the blood. The patient was treated with quinine, but as it seemed to have no influence on the course of the disease, it was omitted, and antipyretics and intestinal antiseptics were used. Many of the normal temperatures seen in the chart are no doubt merely the result of doses of antipyretics. This patient suffered late in the illness from severe pains in the hips, knees and back. H. R., after remaining in hospital for 105 days, was invalided to England, 11th April 1892. He recovered completely, and was one of the unfortunate victims in the loss of H. M. S. *Victoria* in 1893.

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A Mirror of Hospital Practice.

ABDOMINAL SURGERY AT DARBHANGA IN 1896.

By SURGN.-CAPT. E. HAROLD BROWN, M.D.,
Purneah.

(*Continued from page* 328.)

Case 7.—Puri, Hindu, aged 50; multipara; duration two years; girth 47 inches; tumour left-sided.

The patient was an old and very weakly woman, with an enormously distended abdomen. On examination no solid matter could be detected, and the diagnosis arrived at was an unilocular cyst with probably free ascitic fluid.

The patient was perfectly crippled, being scarcely able to sit, and could not walk, owing to the size and weight of the tumour. Pulse 130.

Operation on 21st November.—Abdominal wall not vascular; incison 3 inches; peritoneum much thickened and adherent to the cyst wall. On tapping, several gallons of thin fluid escaped and the abdominal walls slowly collapsed; to expedite emptying of the cyst its anterior wall was incised, the fluid being prevented from passing into the peritoneal cavity by taking the usual precautions. On passing the hand into the cyst cavity some secondary cysts were discovered high up on the left side, and these were also emptied in the same way.

I now seized the cut edge of the cyst wall and gently separated the parietal peritoneum from it, the connection between the two being very intimate, and the whole anterior surface being thus adherent for several inches in all directions. The connections, though firm, were fibrous and there was no hæmorrhage at this stage; but at the sides, the adhesions were softer and more vascular, and, though more easily separated than the others, resulted in fairly free oozing. There were no other adhesions, the sac not having attached itself to any of the neighbouring organs, and the empty cyst was now drawn out, and its pedicle, which was of fair size, was transfixed and ligatured. As no fluid had entered the peritoneal cavity, and as there had been but trifling venous oozing, I did not think it was necessary to irrigate, so closed the wound and dressed it as usual.

When removed from the operating table the patient was in a very favourable condition, the pulse, which was 130 prior to operation, having fallen to 86. She did well for the first four days, the highest temperature being 102·2; there was no sickness or distension, but she complained of a good deal of pain. The dressings were removed on the fifth day, when the temperature was 100·4 and the pulse 116. The wound was healed, but below the umbilicus there was an irregular horse-shoe shaped swelling, extending across the middle line to the extent of two and a half inches. It was rather hard and tender, without fluctuation. The patient's general state was good; the bowels had been moved freely by natural efforts, and there was neither sickness nor tympanites, while the tongue was clean and moist.

The following day the temperature had fallen to 99°, and the parts looked better, the patient also complaining less of pain; the pulse was 100.